ILLINOIS

MEDICAL ASSISTANCE PROGRAM

APPLICATION FOR PARTICIPATION

by

Health Maintenance Organizations

Date of Release: November 2003

State of Illinois
Rod R. Blagojevich
Governor

Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, Illinois 62763-0001

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ARTICLE I

DEFINITIONS

The following terms, the Attachments, Appendices and Exhibits hereto, shall be construed and interpreted as defined herein unless the context otherwise expressly requires a different construction and interpretation. Defined terms will appear with initial capitals in the text. Terms appearing with initial capitals which are not defined in this Article I shall have the meaning set forth in the model Contract set forth in **Appendix A**.

Applicant means a Person submitting a Completed Application for participation in the Medical Assistance Program as an HMO.

Application means this document.

Approval means the determination by the Department that an Applicant satisfies the requirements for participation in the Medical Assistance program as an HMO.

Completed Application means the response to this Application submitted to the Department by an Applicant.

Contract means the written agreement between the Contractor and the Department.

Contracting Area means a geographic area determined by the Department for the purposes of contracting with MCOs as defined in **Appendix B** of this Application.

Contractor means a Person who has submitted a Completed Application which has received approval by the Department, and signed a Contract to provide services to Potential Enrollees.

Department means the Illinois Department of Public Aid and any successor entity.

Health Maintenance Organization or **HMO** means a health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.).

Medical Assistance or Medical Assistance Program means the Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq.) or its successor program and Titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq.) and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-4.35), and the program operated pursuant to the Children's Health Insurance Program Act (215 ILCS 106/1 et seq.), but not including the program operated pursuant to Subsection 25(a)(1) of the Children's Health Insurance Program Act (215 ILCS 106/25(a)(1)).

Person means any individual, corporation, proprietorship, firm, partnership, limited liability company, limited partnership, trust, association, governmental authority or other entity, whether acting in an individual, fiduciary or other capacity.

ARTICLE II

GENERAL INFORMATION

A. STATEMENT OF THE OPPORTUNITY

The Department is accepting Completed Applications from Health Maintenance Organizations for participation in the Medical Assistance Program as a managed care organization (MCO). Applicants may seek to provide services in any combination of the Contracting Areas established by the Department and displayed in **Appendix B**. Cook County must be served as a whole. The effective date of Contracts may vary but all Contracts will automatically renew for a one-year period each August 1, but in no instance will terminate later than July 31, 2006.

The Department has established a maximum enrollment limit of 200,000 Cook County Enrollees per single MCO.

The Department will require all Covered Services, as set forth in **Article V** of the model Contract, be provided to Enrollees. Applicant(s) must propose how these Covered Services will be offered and provided and must designate specific procedures to coordinate care; evaluate utilization of services, quality of services and access to services; and determine Enrollee satisfaction. The Contractor may subcontract with other entities for some of the functions or expertise necessary to fulfill the requirements of this Application. The presence of a subcontractor will not relieve the Contractor of any obligations or responsibilities under the Contract.

Rates to be paid under Contracts entered into as a result of this Application are established by the Department. Rates have been established by the Department for the five Rate Setting Regions and are provided in Attachment I to the model Contract.

Applicants that wish to enter into a Contract must agree to accept all Potential Enrollees.

B. MINIMUM QUALIFICATIONS

To be considered for participation as an HMO, the Applicant must first:

1. meet the Illinois Medicaid State Plan definition of an HMO and be licensed as an HMO in Illinois;

2. meet each of the requirements as set forth in the applicable federal and State statutes, regulations, rules;

3. have a network of Affiliated Providers to render Covered Services to Enrollees and ensure appropriate access to care for those Enrollees;

4. have a coordinated health care delivery system which provides for appropriate referrals and authorization of Covered Services;

5. have a system whereby its Providers are paid on a timely basis for all services rendered pursuant to all applicable state and federal law and the Contract;

6. have a system for submission of Encounter Data pursuant to Exhibit D of the model Contract and other electronic data files as required by the Department;

7. meet all other reporting requirements established by the Department;

8. establish and maintain a quality assurance and utilization management program which, at a minimum, meets the standards set forth in the Health Maintenance Organization Act (215 ILCS 125), applicable federal law and as described in Exhibits A and B of the model Contract;

9. establish and maintain procedures for Enrollee complaints that, at a minimum, meet the standards set forth in the Health Maintenance Organization Act (215 ILCS 125), the Balance Budget Act of 1997, other applicable federal law and as described in the model Contract;

10. establish and maintain a program for educating all Enrollees on preventive health care and appropriate utilization of services;

11. have a mechanism for cooperating with other Providers serving Enrollees;

12. agree to abide by the Department's requirements regarding Marketing; and

13. establish effective Enrollee and Provider services.

ARTICLE III

APPLICATION PROCESS

A. APPLICATION SUBMISSION

1. Components of the Application

This Application provides:

a. A description of managed care under the Medical Assistance Program;

b. A description of the Application process and Persons that may submit a Completed Application;

c. Other requirements to be considered for participation; and

d. Instructions related to the submission of Completed Applications and the materials to be included therein.

2. Approval Process for Applicants

Completed Applications will be screened and evaluated.

a. The following items will be grouped for evaluation purposes and given either a pass or fail rating:

<u>Financial and Organizational Qualifications</u>
Qualified Entity - Tab 2
Ownership and Governance - Tab 2
Disclosure - Tab 2
Financial Information - Tab 2
Accreditation - Tab 2

b. Screening

Each Completed Application passing the financial and organizational requirements of (a) above will then be screened to determine whether the Completed Application was submitted as required and whether the Completed Application is responsive to all requirements of this Application. The Department reserves the right to waive any minor, insubstantial variances in form of any Completed Application. Applicants whose Completed Application fails one or more criteria will be given an opportunity to amend the portion of the Completed Application that did not meet the criteria. The Department will provide the Applicant with written notice of the portion(s) it may amend and provide further direction regarding form and time frames with that transmission.

c. Evaluation

Completed Applications will be reviewed in relation to the requirements of this Application and the model Contract. The Department may take its prior experience and knowledge of the Applicant into account in reviewing Completed Applications. The following items will be grouped for evaluation purposes and given either a pass or fail rating:

Program
Understanding of Managed Care in the Medical Assistance Program - Tab 3
Administrative Capacity - Tab 4
Implementation Plan - Tab 5
Provider Services - Tab 6

Enrollee Services Plan and Prior Experience with Medical Assistance
Enrollee Services Plan - Tab 7
Prior Experience - Tab 7
State's Experience with Applicant, including adverse action against providers in network in the past 10 years - Tab 7

Reporting Capacity
Plan for Reporting - Tab 9
Data System - Tab 9
Electronic Data Interchange - Tab 9

Completed Applications must pass each portion above to receive approval. Nothing shall be deemed a guarantee of any specific level of enrollment in any Applicant's plan.

3. Oral Presentations

Upon review of the Completed Application, the Department reserves the right to require Applicants to make oral presentations of their Completed Applications in Illinois.

4. Site Visits

Upon review of the Completed Application, the Department reserves the right to make on-site visits to the operational facilities of Applicants to further evaluate the Applicants' capacity to perform the duties of a Contractor.

5. Agreement and Compliance with Requirements of the Medical Assistance Program

By submitting a Completed Application, the Applicant agrees to be governed by the terms and conditions as set forth in this Application and the model Contract attached hereto as **Appendix A**. Any response to this Application containing variations from the terms and conditions set forth herein may, at the sole discretion of the Department, render such Completed Application unresponsive. Any inconsistencies between this Application and the Contract shall be construed in accordance with the Contract. Any inconsistencies between this Application and any other contractual instrument shall be construed by the terms and conditions of this Application, except where a subsequent execution of a Contract resulting from this Application occurs. Submission of a Completed Application shall be deemed an acknowledgement by an Applicant that the Applicant has read all of the terms and conditions in or concerning this Application and agrees to be bound by the terms and conditions of this Application and any amendments or attachments hereto.

The Applicant agrees to be bound by any modifications or revisions to the Medical Assistance Program that occur after submission of a Completed Application, regardless of whether those changes occur as a result of legislation, revisions or amendments to the State Plan, Administrative Rules, or Department policy.

6. Costs Incurred by Applicants

The Department shall not be deemed or held liable for any costs or expenses incurred by Applicants related to or arising out of the Completed Application process including, but not limited to, receipt by Applicant of this Application and research and preparation of Completed Applications.

7. Disclosure of Completed Application Contents

During the approval process, Completed Applications will be held in confidence and will not be discussed with competitors. The Department retains all rights to share the contents of any Completed Application with any of its designees for purposes of evaluating Completed Applications.

Once Contracts have been executed, Completed Application contents may be subject to disclosure by the Department under the Illinois Freedom of Information Act (5 ILCS 140/1 et seq.). If the Applicant believes any portion of its Completed Application is exempt from disclosure because it meets the conditions set forth in section 7(1)(g) of the Act, then the Applicant must clearly identify that portion and provide a detailed written explanation as to why it should be considered exempt. Failure to make such identification and explanation will be deemed consent to disclosure. The Department reserves the right to determine whether any identification or explanation is factually or legally sufficient for asserting an exemption under the Act.

The Completed Application and all other material submitted with the Completed Application become the property of the State and will be returned to an Applicant only at the State's option. In the event that confidential and privileged information is sought from the Applicant by a third party through administrative or judicial process, the Applicant shall immediately notify the Department.

8. Authority Over Approval

Approval will be based upon the evaluation of Completed Applications in accordance with the components and criteria which are set forth in this Application. The Department retains

sole authority and discretion to approve based on its evaluation of any and all Completed Applications submitted.

9. Notification of Results of Completed Application Review

Upon the Department's review of the Completed Applications, the Applicant will receive a written notice from the Department of whether the Applicant has been approved.

If the Completed Application is not approved, the Applicant will be given the opportunity to amend its Completed Application to address any deficiencies.

10. Press Releases

Press releases by Applicants that relate in any manner to this Application or any approval or lack of approval which is a result thereof, are not to be made without the prior written consent and approval, as to form and content, from the Department.

B. CONTRACTING PROCESS

Contracts shall be contingent upon CMS approval and the availability of funds as appropriated by the Illinois General Assembly or the United States government.

ARTICLE IV

MANAGED CARE UNDER THE MEDICAL ASSISTANCE PROGRAM

The Department's managed care program is operated under Illinois' approved Medicaid and State Children's Health Insurance Program (SCHIP) State plans and conforms to the requirements of Titles XIX (Medicaid) and XXI (SCHIP) of the federal Social Security Act, the Illinois Children's Health Insurance Program Act, and the Illinois Public Aid Code. Participation by Potential Enrollees is voluntary and Enrollees may disenroll from managed care or a managed care organization at any time. The Department currently contracts with two types of organizations for managed care services, Health Maintenance Organizations (HMOs) and Managed Care Community Networks (MCCNs). Currently five plans contract with the Department, of which one is an MCCN. Four of the five plans provide services only to Potential Enrollees residing in Cook County. One HMO also serves St. Clair, Madison, Randolph, Perry, Washington, Jackson and Williamson Counties.

Approximately 140,000 Participants currently receive their health care under an HMO or MCCN Contract.

ARTICLE V

CAPITATION RATES

A. PAYMENT RATES FOR MEDICAL ASSISTANCE ENROLLEES

The Department has established payment rates for Enrollees for each Rate Setting Region of the State (see Attachment I of the Model Contract, attached hereto as **Appendix A**). Applicants must affirm that they shall perform all duties and obligations as set forth in this Application as amended and the model Contract for the applicable rates established by the Department.

B. GEOGRAPHIC REGIONS

The Contracting Areas have been summarized into five regions for rating purposes. The areas were collapsed to develop a base of data with similar expected costs within each rating region. The regions are:

- Region I, Northwestern Illinois
- Region II, Central Illinois
- Region III, Southern Illinois
- Region IV, Cook County
- Region V, Collar Counties

C. AGE AND GENDER

For the Potential Enrollee population who may become Enrollees, nine age and gender bands are used.

D. HOSPITAL DELIVERY CASE RATE PAYMENT

A separate Hospital Delivery Case Rate, as shown in Attachment I of the model Contract, will be paid to the Contractor for each hospital delivery. This payment will be generated on a monthly basis only from Encounter Data that is accepted as payable by the Department that reflects the hospital delivery.

ARTICLE VI

COMPLETED APPLICATION SUBMISSION REQUIREMENTS

Completed Applications must respond to all requirements of this Application in a straightforward and concise manner and be submitted as described below.

A. COMPLETED APPLICATION IDENTIFICATION

Completed Applications must be labeled (both in its contents and external packaging) as follows:

COMPLETED APPLICATION
SUBMITTED BY: (APPLICANT'S NAME)

B. ADDRESS FOR SUBMISSION

All required copies of the Completed Application must be delivered to the following party:

Illinois Department of Public Aid
Division of Medical Programs
Bureau of Contract Management
Attention: Bureau Chief
201 South Grand Avenue East
Springfield, Illinois 62763-0001

The Department will not accept Completed Applications via facsimile transmission.

C. NUMBER AND FORM OF COPIES

Applicants must submit one original and six (6) copies of the Completed Application each labeled and delivered as indicated above. The original must be submitted unbound and must bear an original authorized signature and be clearly externally designated as the original. The six (6) copies must be bound in three ring binders.

D. COMPLETED APPLICATION FORMAT

Completed Applications must be organized in eleven (11) separate sections tabbed in accordance with the following sections. Any other information requested or which the Applicant believes is relevant should be provided only as a titled supplemental appendix to the Completed Application. If publications are supplied to respond to a requirement, the response should include reference to the document number and page number. Completed Applications not providing this reference will be considered to have no reference material included in the additional documents.

Tabs 1-10 must be completed once to encompass all Contracting Areas covered by the Completed Application. The "Network Characteristics" portion of Tab 6 (4th section) must be completed separately for each Contracting Area covered.

The Completed Application must be organized according to the following Table of Contents. Details concerning the content of each section are provided in subsequent paragraphs of this Article.

Tab 1 - General Information
1. Name of Applicant and Legal Status
2. Designated Contact
3. Public Contracts Number
4. Federal Taxpayer Identification Number
5. Contracting Areas Covered
6. Freedom of Information Act Exemption Request

Tab 2 - Evidence that Applicant is a Qualified Entity
1. Qualified Entity
2. Ownership and Governance
3. Disclosure
4. Financial Information
5. Accreditation

Tab 3 - Applicant's Statement of the Opportunity

Tab 4 - Applicant's Administrative Capacity
1. Personnel
2. References
3. Business Records
4. Medical Records
5. Payments to Providers
6. Subcontracts
7. Fraud and Abuse Procedures

Tab 5 - Applicants' Implementation Plan

Tab 6 - Program Services
1. Covered Services
2. Coordination and Continuity of Care
3. Emergency Services and Post-Stabilization Services
4. Network Characteristics
5. Marketing and Enrollment
6. Provider Relations
7. Quality Assurance Plan
8. Required Minimum Standards of Care
9. Pharmacy Benefit
10. Prohibited Discrimination

Tab 7 - Enrollee Services Plan and Prior Experience with Medical Assistance
1. Enrollee Services Plan
2. Prior Experience

Tab 8 - Acknowledgment of Rates
1. Acknowledgment of Rates
2. Maximum Enrollment Capacity by Contracting Area

Tab 9 - Reporting Capacity
1. Required Reporting
2. Data Processing Environment
3. Electronic Data Interchange

Tab 10 - Index

Tab 11 - Completed Application Attachments

A. Applicant's Illinois Certificate of Authority
B. Resumé and Biographical Affidavit of Key Management and Supervisory Staff
C. Affiliated Provider Information
D. Map(s) Showing Distribution of Providers
E. Quality Assurance Plan

E. TAB 1 - GENERAL INFORMATION

1. Name of Applicant and Legal Status

The Completed Application must clearly identify the name of the Applicant. The Completed Application must identify the legal status of the Applicant from one of the organizational types listed below:

a. Individual
b. Sole proprietor
c. Partnership/ Legal corporation
d. Tax-exempt
e. Corporation providing or billing medical or health care services
f. Corporation NOT providing or billing medical or health care services
g. Governmental entity
h. Nonresident alien
i. Estate or trust
j. Pharmacy (Non-Corp)
k. Pharmacy/Funeral Home/Cemetery (Corp)

l. Other

2. Designated Contact

The Completed Application must clearly indicate the name, title, phone number, e-mail address, facsimile number and address of the individual designated to receive, on behalf of the Applicant, all communications from the Department concerning this Application.

3. Public Contracts Number

Applicants with 15 or more employees must have a Public Contracts Number issued by (or completed application submitted to) the Illinois Department of Human Rights (DHR) prior to submitting this Application. Proof of issuance of a Public Contracts Number must be provided prior to execution of a Contract. DHR may be contacted at 312-814-2431.

4. Federal Taxpayer Identification Number

The Completed Application must provide the Applicant's federal taxpayer identification number.

5. Contracting Areas Covered

The Completed Application must clearly identify all Contracting Areas that the Applicant proposes to serve.

6. Freedom of Information Act Exemption Request

The Applicant must clearly identify any portion of the Completed Application that the Applicant considers exempt from disclosure under the Illinois Freedom of Information Act. A detailed written explanation as to why the specified information should be considered exempt must be provided.

F. TAB 2 - EVIDENCE THAT APPLICANT IS A QUALIFIED ENTITY

1. Qualified Entity

The Application must document that the Applicant is qualified to participate as an HMO as described in Article II of this Application.

a. Submit, as **Completed Application Attachment A,** a copy of the HMO's certificate of authority. Applicants that, at the time of Application submission, do not have a certificate of authority to operate as an HMO in Illinois or are not licensed to operate in some counties for which they are bidding, must obtain an Illinois certificate of authority prior to execution of the Contract. The Application must document that the Applicant reasonably expects to receive the required certificate of authority and by what date it is expected to be received.

b. Provide other documentation that the Applicant satisfies the Illinois Medicaid State Plan Definition of an HMO.

c. Identify any other state where the Applicant or its parent has a principal place of business.

2. Ownership and Governance

a. State the full name, address, and telephone number of the Applicant. Provide the name, work address, home address, date of birth, social security number and gender of each responsible director.

b. Describe the role of the board of directors in governance and policy making.

c. Provide details on the ownership and governance of the organization. This includes submitting a current organizational chart defining levels of ownership, governance and management.

d. Specify the manner in which Enrollees are to be represented, if any, in an advisory or decision-making capacity concerning the Contract.

3. Disclosure

Provide the following:

a. The name, address and FEIN of each Person with an Ownership or Control Interest.

b. Whether any of the Persons so identified is related to another so identified as the individual's spouse, child, brother, sister, or parent.

c. The name of any Person with an Ownership or Controlling Interest, who also has an ownership or control interest of five percent (5%) or more in another disclosing entity, as defined in 42 CFR 455.101, and the name or names of the other disclosing entity.

d. The name and address of any Person with an Ownership or Controlling Interest or is an agent or employee of the Applicant who has been convicted of a criminal offense related to that Person's involvement in any Federal program including any program under Title XVIII, XIX, XX or XXI of the Social Security Act, since the inception of such programs.

e. Whether any Person identified in subsections (a) through (d) above, is terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, from any program under Federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, or has within the last five (5) years been reinstated to participation in any program under Federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, and prior to said reinstatement had been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, in such programs.

4. Financial Information

The Completed Application must provide the information described below for the Applicant itself.

a. Audited financial statements for the two most recent fiscal years for which the statements are available, as submitted to the Department of Insurance. The statements must include a balance sheet, income statement and a statement of cash flows. Statements must be complete with opinions, notes and management

letters. If no audited statements are available, explain why and submit unaudited financial statements.

b. Balance sheet as of the end of the month immediately preceding the month in which application is made.

c. Documentation of lines of credit that are available, including maximum credit amount and available amount.

d. Short-term and long-term debt ratings by at least one nationally recognized rating service, if applicable.

e. Medical loss ratios for the most current two years defined as total medical and hospital cost divided by total premium income.

5. Accreditation

If a nationally recognized accrediting body has accredited the Applicant, supply documentation of that accreditation.

G. TAB 3 - APPLICANT'S STATEMENT OF THE OPPORTUNITY

1. Provide a general narrative description of the proposed programs and services to be provided under the Contract. Describe how these services meet the needs of Enrollees.

2. State in succinct terms the Applicant's understanding of the opportunity presented by this Application. This includes:

   a. demonstrating an understanding of managed care concepts and their applicability to Potential Enrollees. Outline unique areas of concern relevant to this population and describe how the Applicant intends to address them;

   b. describing the organization's ability to control costs while improving the quality of care and improving the health outcomes of Enrollees; and

   c. explaining how the Applicant will improve the general health status of the Potential Enrollee population in the area that the Applicant proposes to serve under the Contract.

H. TAB 4 - APPLICANT'S ADMINISTRATIVE CAPACITY

1. Personnel

a. Specify the Applicant's organizational structure as it would pertain to the Contract during implementation and ongoing operations.

b. Supply the name, title, address, phone number and e-mail address of the individual who would have responsibility for monitoring and ensuring the performance of duties and obligations under a Contract.

c. Indicate, by name, title and responsibility, the individuals who will be responsible for ensuring each function related to implementation and ongoing management of the Contract is performed.

d. Provide the names and titles of key management and supervisory staff relevant to a Contract. Attach current resumé for each individual as **Completed Application Attachment B**. If the individual was required to submit a biographical affidavit to the Department of Insurance, include a copy of that submission with the resumé.

e. Identify the officer(s) of the Applicant who have final responsibility for medical quality assurance and the credentialing process. Document how they are qualified to fulfill this role.

2. References

The Completed Application must provide at least three references the Department may contact concerning the Applicant's qualification to perform the duties and services described in this Application. For each reference, Applicants must provide the name of the organization; the name, title, address and telephone number of the individual to contact for the reference; and the nature of the relationship of the organization to the Applicant. Do not include Department staff as references.

3. Business Records

Describe the Applicant's plan for preserving required records pursuant to **Article 5.8** of the model Contract.

4. Medical Records

Describe Applicant's plan for maintaining patient records pursuant to **Article 5.8** of the model Contract.

5. Payments to Providers

a. Describe the payment mechanisms by which all Providers, both Affiliated and non-Affiliated, will be paid by the plan. Include a description of how the Applicant will comply with timely payment requirements required by **Article 5.15** of the model Contract and consistent with the Claims Payment Procedure described at 42 U.S.C. § 1396a(a)(37)(A) and Illinois Public Act 91-0605.

b. Describe the Applicant's procedure for processing claims and making required payments for Emergency Services and Post-Stabilization Services provided by non-Affiliated Providers pursuant to **Article 5.15** of the model Contract. Provide assurances that the Applicant will make reimbursement at least equivalent to the Department's rates for such services. (Refer to **Appendix C**).

6. Subcontracts

a. Provide assurances that the Applicant will comply with the provisions of **Article 5.18** of the model Contract. Describe the Applicant's process for managing subcontracts.

b. Identify any Persons other than Providers with whom the organization intends to subcontract under the Contract. Provide the subcontractor's name, address and the maximum payment under the subcontract.

7. Fraud and Abuse Procedures

Describe the Applicant's plan to conform to fraud and abuse requirements pursuant to **Article 5.22** of the model Contract.

I. TAB 5 -APPLICANT'S IMPLEMENTATION PLAN

1. Describe the Applicant's plan for implementing and operating under the Contract.

2. Provide separate work plan schematic displays showing tasks and time frames for both implementation and ongoing operation.

3. Outline a plan that will ensure continuity of ongoing patient care.

J. TAB 6 -PROGRAM SERVICES

The Completed Application must demonstrate the Applicant's capacity to perform all the services and duties of the model Contract attached hereto as **Appendix A**.

1. Covered Services

a. Describe in detail the Applicant's plan for providing all Covered Services. Any exceptions to Covered Services claimed as a right of conscience exclusion, pursuant to 745 ILCS 70/1 et seq., must be explicitly stated.

b. Describe the Applicant's plan for establishing toll-free telephone services pursuant to **Article 5.1(k)** of the model Contract.

2. Coordination and Continuity of Care

a. Describe arrangements for cooperating with other providers serving Enrollees.

b. Describe the Applicant's referral and service authorization procedures for both Affiliated and non-Affiliated Providers.

c. Explain the process for assuring continuity of care.

d. Describe the Applicant's plan for monitoring denied requests for services for both Affiliated and non-Affiliated providers.

3. Emergency Services and Post-Stabilization Services

Describe the Applicant's plan for satisfying the requirements of **Article 5.1(h) and Article 5.1(i)** of the model Contract. Explain how the Applicant will meet standards for availability and timeliness of response.

4. Network Characteristics

a. Describe the network of Affiliated hospitals, health centers, pharmacies, physicians, ancillary providers, and other entities to be included as Providers. Explain how Applicant will ensure that all Physicians providing services shall have and maintain admitting privileges and, as appropriate, delivery privileges at an Affiliated Plan hospital, as described in **Article 5.14** of the model contract. Explain how perinatal and trauma networks will be accounted for in the HMO's service network. Explain how the Applicant will coordinate with other service providers, as described in **Article 5.12(f)** of the model Contract.

Describe the Applicant's process for assuring that all affiliations prohibited by **Article 5.7** of the model Contract are avoided.

b. As **Completed Application Attachment C,** provide the corporate (or organizational) name of each Affiliated Provider, its Medical Assistance Provider Number, address of its principal place of business, and the address of all sites at which patient care will be provided. Describe the nature of the business relationship between the Applicant and each Affiliated Provider, including whether a written subcontract exists, whether the subcontract is for employment, independent contractor, or other arrangement and the date (month, year) and duration of the subcontract. Provide a standard subcontract for each

Provider type. If a letter of intent has been signed but a subcontract has not been executed, provide a copy of the letter of intent.

c. Demonstrate how the network will achieve the Medical Assistance Program's goal to ensure that Enrollees have access to the appropriate health care services in the appropriate setting in a timely fashion. The Applicant's scope of activities must include directly providing and coordinating the continuum of health care services, especially primary and preventive care, and performing care coordination services.

d. For each Affiliated health care entity, attest that it is fully licensed to operate. For each Affiliated hospital, indicate the date and outcome of the latest survey of the entity performed by the Joint Commission on Accreditation of Healthcare Organizations. For each Affiliated health center, attest that it is a Federally Qualified Health Center or Rural Health Clinic or other facility. Attest that the Applicant will have sufficient pharmacy operating locations and hours to meet the access needs of Enrollees.

e. Provide a map as **Completed Application Attachment D** indicating the distribution of Affiliated Providers, including Primary Care Providers, specialist physicians, hospitals (including perinatal level three hospitals and other tertiary facilities) and pharmacies available in each Contracting Area to be served. If a clear map of Primary Care Providers is not feasible due to the density of providers in one area, state this as the reason for not providing this map and cite the section of the Completed Application that provides the names and addresses of all Primary Care Providers.

f. Describe how the geographic distribution of Affiliated Providers other than Primary Care Providers, specialist physicians, hospitals and pharmacies will assure adequate access to services throughout the Contracting Area.

g. Describe how services will be provided by a non-Affiliated provider, including sub-specialists, for specialty care or second opinions if no Affiliated provider is available.

h. Describe how the Applicant will provide services to treat mental illness.

i. Describe how the Applicant will provide services to treat alcohol and substance abuse.

j. State the annual operational capacity of each Affiliated Provider to provide patient care within the proposed network. Describe the Applicant's capacity for inpatient, outpatient, and emergency department visits.

k. List the pediatric specialists who will be available for the treatment of chronically ill children who are Enrollees. Provide by subspecialty type, the name and address of each pediatrician in the Applicant's network. Also indicate for each physician listed the number of chronically ill pediatric patients served during the most recent period for which data is readily available.

l. Describe how specialty care that chronically ill children receive will be coordinated both across specialties and with primary care.

m. Provide analysis sufficient to demonstrate that the Applicant will be able to meet and maintain the primary care physician to Enrollee, the obstetrician/gynecologist to Enrollee and the pediatrician to Enrollee ratios required in **Article 5.14** of the model Contract.

n. Describe how the Applicant will ensure female Enrollees have the required access to Women's Health Care Providers.

o. Describe how the Applicant will assure that other access requirements of the model Contract will be met and maintained.

5. Marketing and Enrollment

a. Explain how the Applicant will satisfy each requirement of **Article 5.2** and **Article 5.3** of the model Contract.

b. Describe in detail how the Applicant will satisfy all enrollment, disenrollment and coverage requirements of **Article IV** of the model Contract.

6. Provider Relations

Describe the Applicant's plan for achieving and maintaining constructive relationships with Providers and document the capacity to perform all required duties of the model Contract. Explain how Applicant will inform Providers of Contract requirements. Describe the Provider grievance process the Applicant will use under the Contract.

7. Quality Assurance Plan

a. The Completed Application must describe the Applicant's Quality Assurance Plan (QAP). The Completed Application must document that the QAP will conform to the requirements of Exhibit A of the model Contract. A copy of the current QAP should be attached as **Completed Application Attachment E**. The Completed Application must indicate whether any practices may be altered to meet the needs of Enrollees.

b. Describe the process for monitoring the QAP. Include the criteria used. Detail personnel, frequency and outcome of process when issues are identified.

c. Identify protocols in place for surgical, medical, outpatient or other case review.

d. Describe current membership and provider surveys conducted. Outline process, frequencies and information gathered. Attach a sample of each.

e. Describe the Applicant's current utilization management program(s). Include:

(1) A detailed description of utilization management program(s).

(2) An explanation of the process for monitoring the utilization management program. Include the criteria used.

f. Describe the Applicant's plan for satisfying the Department's utilization management requirements as set forth in **Article 5.5** and **Exhibit B** of the model Contract.

g. Describe the credentials required of each Provider included within the proposed network. Describe the procedures used to verify those credentials. Attach the credentialing and recredentialing procedures to be used by the Applicant. For each Provider, attest that he/she possesses a valid license to practice in his/her designated profession (e.g., medicine, podiatry), and indicate whether the preponderance of his/her professional activities is in the provision of patient care. For each physician provider, indicate whether the preponderance of his/her patient care activity is in primary care or in specialty care.

h. Describe the Applicant's current program for monitoring the quality of care provided, including the medical record review process. Include a description of quality improvement activities performed in the past two years. Include a description of the Peer Review Program.

i. Describe the Applicant's plan for monitoring of delegated activities.

j. Describe the Applicant's plan/process for measuring HEDIS, or Department defined measures identified in Exhibit A of the model Contract.

8. Required Minimum Standards of Care

Describe how the Applicant will satisfy the requirements of **Article 5.12** of the model Contract to provide Healthy Kids services to Enrollees younger than 21 years of age; the Preventive Medicine Schedule established for Enrollees 21 years of age and older and required Maternity Care.

9. Pharmacy Benefit

a. Describe the Applicant's procedure for assuring that its pharmacy benefit is no more restrictive than the Department's pharmaceutical program and that it meets the requirements of **Article 5.1(l)** of the model Contract. The Department's most current preferred drug list is available at:

http://www.dpaillinois.com/preferred/ or http://www.ildpa.com/preferred/

b. Describe any pharmaceutical prior approval or medical necessity processes the Applicant will establish under the Contract.

10. Prohibited Discrimination

Explain how Applicant will assure that no prohibited discrimination will occur.

K. TAB 7 -ENROLLEE SERVICES PLAN AND PRIOR EXPERIENCE WITH MEDICAL ASSISTANCE

1. Enrollee Services Plan

The Completed Application must describe in detail the Applicant's member services program. In particular, the Completed Application must address the following:

a. Primary Care Provider site assignment, change of site policies and process, timely distribution of Enrollee identification cards and other enrollment materials;

b. toll-free twenty-four hour telephone coverage detailed in **Article 5.1(k)** of the model Contract;

c. provision for other Enrollee services requests (e.g., disenrollment, complaints);

d. provision of "Basic Information: as required in **Article 5.4** of the model Contract;

e. Enrollee grievance and appeals procedure as required in **Article 5.16** of the model Contract;

f. language requirements as detailed in **Article 2.4** of the model Contract;

g. plan for the Health Education program required by **Article 5.11** of the model Contract.

2. Prior Experience

a. Describe the Applicant's experience serving Participants.

b. Describe any experience as fiscal intermediary for Medical Assistance or other third-party billing systems that may be relevant to the Medical Assistance Program.

c. Describe any past or current working relationships with entities or community organizations in Illinois that will enhance the organization's ability to fulfill the requirements.

d. Describe any relevant experience with other State of Illinois agencies.

e. Applicants who have no prior experience as referenced above should state qualifications or past experience which is comparable.

L. TAB 8 - ACKNOWLEDGMENT OF RATES

1. Acknowledgment of Rates

Submission of a Completed Application is an acknowledgment by the Applicant that the rates established by the Department are the total payment that will be received for services provided for Enrollees under a Contract.

2. Maximum Enrollment Capacity by Contracting Area

The Completed Application must clearly identify the maximum number of Enrollees the Applicant proposes to enroll in each Contracting Area that the Applicant proposes to serve. If applicable, this number must fall within the limits established in Article II(A) of this Application or the Completed Application must justify the variation.

M. TAB 9 - REPORTING CAPACITY

The Completed Application must document the Applicant's capacity to fulfill all responsibilities described in **Article 5.10** of the model Contract.

1. Required Reporting

The Completed Application must explain in detail the Applicant's plan for supplying the reports listed in **Exhibit C** of the model Contract.

2. Data Processing Environment

The Completed Application must describe the Applicant's data processing environment including, hardware, software, support staff and data processing center shift coverage.

3. Electronic Data Interchange

The Completed Application must demonstrate the Applicant's ability to exchange data electronically with the Department pursuant to **Article 5.9** of the model Contract.

The Department's Medicaid Management Information System (MMIS) is operated by the State of Illinois, Department of Central Management Services (DCMS) which provides all of the Department's mainframe computing resources. The current mainframe environment includes an IBM ES9000/972 computer utilizing ZO/S architecture. The MMIS is comprised of numerous on-line IMS and DB2 databases. The preferred telecommunication links utilize TCP/IP, FTP, Websphere MQ, and TN3270 for terminal emulation where needed.

N. TAB 10 - INDEX

The Applicant must provide a cross-referenced index to the Completed Application that references each paragraph of the requirements in this Article VI of this Application and identifies, by specific item, the location of Applicant's response to the requirement.

O. TAB 11 - COMPLETED APPLICATION ATTACHMENTS

Complete the following forms and attach them to the Completed Application as instructed.

A. Applicant's Illinois Certificate of Authority
B. Resumé and Biographical Affidavit of Key Management and Supervisory Staff
C. Affiliated Provider Information
D. Map(s) Showing Distribution of Providers
E. Quality Assurance Plan

COMPLETED APPLICATION ATTACHMENT A

Applicant's Illinois Certificate of Authority

COMPLETED APPLICATION ATTACHMENT B

Resumé and Biographical Affidavit of Key Management and Supervisory Staff

COMPLETED APPLICATION ATTACHMENT C

Affiliated Provider Information

COMPLETED APPLICATION ATTACHMENT D

Map(s) Showing Distribution of Providers

COMPLETED APPLICATION ATTACHMENT E

Quality Assurance Plan

APPENDIX A

MODEL HMO CONTRACT

APPENDIX B

Contracting Areas by Region

Region 1 Northwestern Illinois Contracting Areas	Region 2 Central Illinois Contracting Areas	Region 3 Southern Illinois Contracting Areas	Region 4 Cook County Contracting Area	Region 5 Collar Counties Contracting Areas
Boone	Adams	Alexander	Cook	DuPage
Bureau	Brown	Bond		Grundy
Carroll	Calhoun	Clay		Kane
DeKalb	Cass	Clinton		Kankakee
Fulton	Champaign	Crawford		Kendall
Henderson	Christian	Edwards		Lake
Henry	Clark	Effingham		McHenry
JoDaviess	Coles	Fayette		Will
Knox	Cumberland	Franklin		
LaSalle	DeWitt	Gallatin		
Lee	Douglas	Hamilton		
Marshall	Edgar	Hardin		
Mercer	Ford	Jackson		
Ogle	Greene	Jasper		
Peoria	Hancock	Jefferson		
Putnam	Iroquois	Johnson		
Rock Island	Jersey	Lawrence		
Stark	Livingston	Madison		
Stephenson	Logan	Marion		
Tazewell	Macon	Masac		
Warren	Macoupin	Monroe		
Whiteside	Mason	Perry		
Winnebago	McDonough	Pope		
Woodford	McLean	Pulaski		
	Menard	Randolph		
	Montgomery	Richland		
	Morgan	Saline		
	Moultrie	St. Clair		
	Piatt	Union		
	Pike	Wabash		
	Sangamon	Washington		
	Schuyler	Wayne		
	Scott	White		
	Shelby	Williamson		
	Vermilion			

APPENDIX C

DEPARTMENT RATES FOR EMERGENCY SERVICES AND POST STABILIZATION SERVICES

*Hospital Emergency Room Rates
(current rates, subject to change)

Level	Reimbursement Amount
Emergency Level I	$181.00
Emergency Level II	$ 67.00
Non-emergency/screening	$ 26.00

*Non-salaried physicians billing for emergency room services (whether emergency is or is not present) should be paid by the MCO on a fee-for-service basis using the billed CPT code.

Department fee-for-service rates for post stabilization services and physician services can be found on the Department's Web site http://www.dpaillinois.com/ or http://www.ildpa.com